VERMONT

Office of Vermont Health Access *Agency of Human Services*

Vermont Health Access Pharmacy Benefit Management Program Provider Manual 2009

MedMetrics HealthPartners

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Introduction

Pharmacy claims for Vermont's publicly funded programs are processed by our pharmacy benefit management company – **MedMetrics Health Partners (MHP)**.

This Provider Manual consists of a list of contacts, program specific information, a list of information resources and web links, and payer specifications. All of this material will be updated periodically as needed. For the most current version go to:

http://ovha.vermont.gov/for-providers

For Vermont's purposes, here and hereafter all references to Vermont Medicaid will mean all publicly funded health assistance programs in current use (Medicaid, Dr. Dynasaur, Vermont Health Access Plan (VHAP), PC Plus, VHAP-Pharmacy, VScript, VScript Expanded, VPharm, Healthy Vermonters, General Assistance and HIV/AIDS Medication Assistance).

Help Desk Telephone Numbers

Responsibility	Help Desk	Phone Numbers	Availability
Recipient:			
Beneficiary	Vermont Member Services Unit	800-250-8427	M-F 8:00AM – 4:30PM (excluding holidays)
Provider:			
EDS*	Provider Enrollment and Payment	800-925-1706 (in state) 802-878-7871 (out of state)	M-F 8:00AM –5:00PM
MedMetrics Health Partners	Pharmacy Help Desk / Claims-related Pharmacy Call Center	800-918-7545	24/7/365
MedMetrics Health Partners	Clinical Call Center /Prior Authorizations	800-918-7549 866-767-2649 (fax)	24/7/365
Diane Neal, RPh MedMetrics Health Partners	Clinical Staff (Williston, Vermont)	802-879-5605 802-879-5919 (fax)	M-F 8:00AM – 4:30PM (excluding holidays)
Jean McCandless AMAP Coordinator Vermont Department of Health	Prior Authorization (Designated drugs on the HIV/ AIDS Medication Assistance Program list only)	802-527-5576 (phone)	M-F 8:00AM – 4:30PM (excluding holidays)
Nancy Miner, CPhT MedMetrics Health Partners	Program Representative	802-879-5638	M-F 8:00AM – 4:30PM (excluding holidays)

*EDS will continue to handle provider enrollments and process and distribute pharmacy provider reimbursements and remittance advices (RAs).

Important Addresses

Provider Paper Claims Billing Address:	**Notes:**
MedMetrics Health Partners Vermont Medicaid Paper Claims Processing Unit 312 Hurricane Lane, Suite 201 Williston, VT 05495 (802) 879-5638	Format: Universal Claim Form (UCF)

MedMetrics (MHP)/Office of Vermont Health Access (OVHA) Operations
312 Hurricane Lane, Suite 201 Williston, VT 05495

Important Vermont Pharmacy Program Web Links

Office of Vermont Health Access (OVHA): http://ovha.vermont.gov/

OVHA/MHP Provider Services and Claims Processing: http://ovha.vermont.gov/for-providers

EDS Provider Enrollment and Payment: www.vtmedicaid.com/

Coverage Chart for Pharmacy Only Programs:

http://ovha.vermont.gov/for-providers/ovha-plan-coverage

Medicare Non-Covered Drug Grid:

http://ovha.vermont.gov/for-providers/medicare-part-d-resources

Beneficiary Aid Category List:

http://www.vtmedicaid.com/Information/whatsnew.html

Vermont Health Access Pharmacy Benefit Management Program:

http://ovha.vermont.gov/for-providers/pharmacy-benefits-management-program-1

Drug Utilization Review Board:

http://ovha.vermont.gov/administration

Preferred Drug List and Drugs that Require PA: http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

Clinical Criteria and Advisories: http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

Prior Authorization Forms:
http://ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms

Pharmacy Bulletins and Alerts: http://ovha.vermont.gov/for-providers/pharmacy-programs-bulletins-alerts

Active Enrolled Provider/Prescriber Listing: www.vtmedicaid.com/Downloads/manuals.html

VScript Expanded Participating Labelers – Numeric: http://ovha.vermont.gov/for-providers/v-scriptparticipants06-29-07numeric.pdf

VScript Expanded Participating Labelers – Alpha: http://ovha.vermont.gov/for-providers/v-script-labelers
http://ovha.vermont.gov/for-providers/v-scriptparticipants06-29-07alphabetical.pdf

Pharmacy Provider Manual: http://ovha.vermont.gov/for-providers

Pharmacy Payer Specifications: http://ovha.vermont.gov/for-providers/medmetrics-health-partners-mhp-billing-information

Drug Coverage

General coverage rules are as follows:

Medicaid as a unique program covers most prescription drugs with the exceptions found here. General coverage conditions under Medicaid pharmacy and the pharmacy only programs can be found at:

http://ovha.vermont.gov/for-providers/ovha-plan-coverage

Each beneficiary is assigned an Aid Category Code. This code identifies the program that provides coverage. A crosswalk of programs to codes can be found in the Aid Category List: http://www.vtmedicaid.com/Information/whatsnew.html

The following drugs/drug classes are not covered through the pharmacy benefit:

1. DESI drugs
2. Experimental drugs (DEA = 1)
3. Fertility agents
4. OTCs not covered: shampoos and most non-drug items

Drug coverage is contingent upon CMS rebate agreements with the manufacturers. VScript Expanded and VPharm 3 have additional rebate requirements. Exception: Diabetic supplies will pay regardless of rebate, subject to prior authorization requirements.

Some supplies may be submitted on-line (e.g., diabetic supplies and family planning supplies such as condoms). The supply must have a corresponding NDC.

Claims for all other supplies, including those used for incontinence, should be submitted on a CMS 1500 form to EDS.

Nutritional supplements may be submitted online.

Exceptions to VScript Maintenance List

The VScript drug program provides coverage for prescription medications (and limited OTCs) which are considered maintenance therapies. If a claim denies for a drug because it is not on the VScript Maintenance List (Appendix A), and you believe that the drug product (or drug class) should be covered for all VScript patients because it is more often than not utilized for chronic maintenance purposes, you may call the Clinical Call Center at 800-918-7549 with your recommendations. Please note, however, that the narcotic class of agents, both long-acting and short-acting agents, is not considered to be a maintenance drug category.

If a claim denies for a VScript member because the drug is not on the VScript maintenance list and its use for this individual patient will be for maintenance purposes, then please advise the patient to contact his or her physician to request a Prior Authorization.

Custom Program Messaging

In an effort to help pharmacies to better know / understand a beneficiary's program eligibility/coverage, custom messages have been added to the claim processing responses. The following message will appear when a claim is processed for a member in the respective program. This message will appear regardless of how the claim processes (i.e., pays or rejects) and will appear after specific messaging that refers to the cause of a reject.

MEDICAID / DR. DYNASAUR	"Medicaid coverage"
VHAP	"VHAP Coverage"
VSCRIPT	"Maintenance List Applies"
VSCIPT EXPANDED	"Limited Maintenance List Applies"
VPHARM 1 (VPHARM/VHAP)	"Part D VHAP Wrap"
VPHARM 2 (VPHARM/VSCRIPT)	"Part D Maintenance-Only Wrap"
VPHARM 3 (VPHARM/VSCRIPT EXP)	"Part D Ltd. Maintenance Wrap"
ESI (EMPLOYER-SPONSORED INSURANCE CHRONIC CARE WRAP)	"Maintenance List Applies"

Prior Authorization

Prior authorization may be required for all programs except General Assistance and Healthy Vermonters.

All drugs and supplies requiring prior authorization can be identified on the Preferred Drug List. The List and Criteria for prior authorization can be found at:

http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

Prior authorizations may be faxed to the number below.

Responsibility	Help Desk	Phone Numbers	Availability
MedMetrics Health Partners	Clinical Call Center /Prior Authorizations	800-918-7549 866-767-2649 (fax)	24/7/365

Emergency 72-Hour Fill

An emergency fill provision can be instituted by MedMetrics when a required prior authorization has not been secured, and the need to fill the prescription is determined to be an emergency. If the prescriber cannot be reached to obtain the required prior authorization, the pharmacist may contact MedMetrics for authorization to dispense an emergency supply to last up to 72 hours. If the emergency persists, refills can be available. This emergency 72-hour fill provision is Federal law (Title 19, Section 1927(D)(5)(b)) and is applicable only to medications that are covered by Vermont's pharmacy programs.

General Assistance

Beneficiaries may be enrolled in General Assistance in one of two ways:

- General Assistance only; i.e., there is no other "primary" Medicaid coverage; *or*
- General Assistance as secondary coverage with another Medicaid program as primary.

Coverage is limited to classes of drugs identified as likely to create an emergency if not covered.

In those cases where a beneficiary makes a payment, the provider must submit the amount in the PATIENT PAID AMOUNT field.

Generic Substitution Policy

Vermont law requires that when available, the therapeutically equivalent generic product should be dispensed.

MAC pricing may be overridden by the provider in the following conditions:

1. The prescriber has mandated brand, noting "Brand Medically Necessary" on the prescription and indicated in writing or verbally why a brand is required. In this case, the pharmacy provider should submit a Dispense as Written Code (DAW) of "1".
2. The generic is not available in the marketplace. In this case, the pharmacy provider should submit a Dispense as Written Code (DAW) of "8". Note that this does not mean that it is not available in the store. DAW8 may only be used when the generic is not generally available in the community. The provider should keep appropriate documentation to support this condition.
3. DAW1 cannot be used to override the requirements of the OVHA Preferred Drug List.

Additionally:

1. Brand drugs that are considered to have a narrow therapeutic index will bypass MAC pricing.

2. In select situations, the state reserves the right to make the determination that a branded product is the preferred product when a newly FDA-approved generic equivalent agent proves more costly to the State than its branded counterpart. If, upon launch, it is determined that the generic will be priced at a level greater than the net cost of the brand, OVHA may require a prior authorization for the generic until that time when generic pricing falls below that of the net cost of the branded product.

Long-Term Care (LTC) Nursing Home Claims

LTC nursing home claims are identified by a value of "3" in the PATIENT LOCATION field on the claim.

Some drugs and supplies are not covered for LTC nursing home patients through POS as they are covered in the patient's per-diem. With the exception of insulin, needles and syringes, OTC drugs and products are not covered.

There is no copay to the recipient on LTC claims.

Providers submitting LTC claims are limited to one dispensing fee per patient per covered drug per month ("per month" will be considered 75% of a 34-day supply; this allows the provider to a limit of one dispense fee per every 25 days). "Per covered drug" will be considered "per GPI" (*Definition:* A GPI, or Generic Product Indicator, includes all drugs sharing the same chemical composition, in the same strength, in the same form and that are administered via the same route.) Providers may request an override to the single dispense fee limit for mitigating circumstances by contacting the Pharmacy Call Center at (800) 918-7545. Acceptable circumstances for overriding the single dispense fee limit are:

- The physician has prescribed a second round of medication within the 25-day period.
- The physician has increased the dose.
- The medication did not last for the intended days supply.
- The drug has been compromised by accident (e.g., contaminated or destroyed).
- The medication is being dispensed due to the patient's LOA (leave of absence) from the institution.
- Note: The dispensing of controlled substances is limited due to concern regarding patient's ability to take appropriately.

Except for controlled substances, unused or modified unit dose medication that is in reusable condition and which may be returned to a pharmacy pursuant to state laws, rules or regulations shall be returned from LTC facilities to the provider pharmacy. The provider should resubmit the claim with the appropriate quantity dispensed.

Special Claims

Multi-Ingredient Compound Claims

- Ingredients will be priced at the lesser of AWP – 11.9%, the MAC, or the FUL.
- The ingredients' costs will be totaled and priced at the lesser of the calculated cost or the claim's U&C cost.
- Containers other than syringes are included in the dispensing fee.
- Syringes must be billed as part of the compounded claim. They are not subject to a separate dispensing fee or compounding fee.
- A compound fee (professional services fee) of $15.00 will be automatically added to all prescriptions submitted with a compound indicator of "2" (in addition to the regular $4.75 in-state or $3.65 out-of-state dispensing fee).
    - All compounds must contain **more than one ingredient**. Compounds submitted with only one ingredient will reject with a reject code of 76 with local messaging of "Minimum ingredients of 2."
    - **Compound indicator must be "2"** (indicating a multi-ingredient compound).
    - **NDC field in claim segment (i.e. Product/Service ID)** (not individual ingredients) must contain **11 zeros**. If an actual individual NDC is submitted in the Product/Service ID, the claim will reject with a reject code of 70 with local messaging of "Submit 11 zeros in the Product/Service ID and complete compound detail – more than 1 ingredient required."

Any questions about the submission of claims for compounded medications should be directed to the MedMetrics Clinical Call Center at 1-800-918-7549.

Paper Claims

- The Universal Claim Form (UCF) will be required for all paper claims.
- The UCF should be submitted to MHP for processing.
- UCFs may be obtained from Moore Document Solutions:

    Moore Document Solutions
    410 N. 44th Street, Suite 300
    Phoenix, AZ 85008
    800-635-9500

Specialty Pharmacy

The Office of Vermont Health Access (OVHA) has selected two specialty pharmacies to serve Medicaid beneficiaries (where Medicaid is the primary insurer).

- Effective October 1st, 2008 Wilcox Medical dba Wilcox Home Infusion will be the specialty pharmacy for Synagis®, which is administered to prevent respiratory syncytial virus (RSV).

- Effective November 3rd, 2008 ICORE Healthcare, LLC, partnering with MedMetrics Health Partners, will be the specialty pharmacy for other select specialty drugs. This includes, but is not limited to, hemophilia factors, growth hormones, multiple sclerosis self-injectables, hepatitis C (ribavirin and injectables), and Elaprase® (for Hunter's Syndrome).

- Effective February 16th, 2009, drugs used to treat rheumatoid arthritis, psoriasis, psoriatic arthritis, and ankylosing spondylitis will be added to ICORE's Specialty program. This includes Humira (adalimumab), Enbrel (etanercept), Raptiva (efalizumab), and Kineret. Other drugs will be added to the specialty program periodically.

Dispensing of these medications is limited to these pharmacies for Medicaid beneficiaries where Medicaid is the primary insurer.

Prospective Drug Utilization Review (ProDUR)

ProDUR is an integral part of the Vermont Medicaid claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the available medical history, focusing on those patients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system addresses situations in which potential drug problems may exist. ProDUR performed prior to dispensing ensures that patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available.

Because ProDUR examines claims from all participating pharmacies, drugs which interact or are affected by previously dispensed medications can be detected. While the pharmacist uses his/her education and professional judgment in all aspects of dispensing, ProDUR is intended an informational tool to aid the pharmacist.

Therapeutic Problems
The following ProDUR Reason of Service types will deny for the Vermont Medicaid program:

- Drug-to-Drug Interaction
- Therapeutic Duplication
- Ingredient Duplication

ProDUR Edits that deny may be overridden at POS using the interactive NCPDP DUR override codes (see below). ProDUR denial edits will apply to all media types.

DUR Override Processing (NCPDP Reject Code 88)

When a claim is rejected for a DUR edit, pharmacies may override the denial by submitting the appropriate DUR Reason for Service, Professional Service, and Result of Service codes.

Below you will find a chart that details the Professional Service and Result of Service codes that will override a claim that has been denied for Drug-to-Drug Interaction, Ingredient Duplication and/or Therapeutic Duplication. Note that the designated Professional Service Code must accompany the appropriate Result of Service code as indicated in the chart to allow the override.

DUR REJECT OVERRIDE PROCESSING (NCPDP Reject Code 88)

The valid DUR Reason for Service Codes for Vermont Medicaid are:

DD - Drug-Drug Interaction
ID - Ingredient Duplication
TD - Therapeutic Duplication

The only acceptable Professional Service Codes are:

MR – Medication Review
M0 – Prescriber Consulted
R0 – Pharmacist Consulted Other

Please note that the designated Professional Service Code must accompany the appropriate Result of Service code as indicated below to allow the override:

DUR REASON FOR SERVICE (Conflict)	PROFESSIONAL SERVICE CODE (Intervention)		RESULT OF SERVICE CODE (Outcome)	
	CODE	**DESCRIPTION**	**CODE**	**DESCRIPTION**
DD, ID, TD				
	MR	Medication review	**1B**	Filled prescription as is
	M0	Prescriber consulted		
	R0	Consulted other		
	M0	Prescriber consulted	**1C**	Filled with different dose
	R0	Consulted other		
	MR	Medication review	**1D**	Filled with different directions
	M0	Prescriber consulted		
	R0	Consulted other		
	MR	Medication review	**3E**	Therapy changed
	M0	Prescriber consulted		
	R0	Consulted other		

Days Supply

Accurate days supply reports are required on all claims. Submitting incorrect days supply information in the days supply field can cause false ProDUR messages or claim denial for that particular claim and/or for drug claims that are submitted in the future.

ProDUR Support

MHP's Pharmacy Call Center is available 24 hours per day, seven days per week. The telephone number is 800-918-7545. Alert message information is available from the Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Call Center about ProDUR messages at the time of dispensing. The Call Center can provide claims information on all error messages which are sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The Pharmacy Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. MHP has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, MHP staff pharmacists are available for consultation.

ProDUR Alert/Error Messages

All messages appear in the claims adjudication transmission. See Payer Specifications for more information.

Timely Filing Limits

Most providers submitting point of sale submit their claims at the time of dispensing. However, there may be mitigating reasons that require a claim to be submitted after the fact.

- For all original claims, reversals and re-bills, the timely filing limit is **183 days** from the date of service (DOS).

- Claims that exceed the prescribed timely filing limit will deny.

- When appropriate, contact MHP for consideration of an override to timely filing limits.

- Requests for overrides will be considered for:
  1. Retroactive beneficiary eligibility
  2. COB delay
  3. Denial date (depending on original adjudication date)
  4. At the State's request

- Overrides for timely filing limits exceeded greater than two years from the date of service will not be authorized.

Requests for overrides should be mailed to:

MedMetrics Health Partners
Vermont Medicaid Paper Claims Processing Unit
312 Hurricane Lane, Suite 201
Williston, VT 05495

Call the MHP Program Representative with any questions at (802) 879-5638.

Dispensing Limits

Days Supply:

- Non-maintenance drugs (*Definition:* medications used on an "as needed" basis*)* are subject to a per claim days' supply maximum limit of **34**. There is no days supply minimum.
- Maintenance drugs (*Definition:* used continuously for 30 days or more*)* are subject to a per-claim minimum days' supply of 30 and a maximum days supply of **102.** If there are extenuating circumstances in an individual case which, in the judgment of the prescribing physician, dictate a shorter prescribing period, the supply may be for less than 30 days. Certain drugs have maximum quantity limits other than described here (see "Quantity Limits" below).
- A 102 day supply is allowed for all covered Vitamins.
- V-Script beneficiaries may receive up to a **90**-day supply of any drug on their coverage list. The V-Script Covered and Non-Covered Drug Lists are included as appendices at the back of this document.
- Claims will deny if the days supply limit is exceeded.

Exceptions to standard days supply limits:

1. Fluoride quantity limit is 102.
2. Oral Contraceptives may be dispensed in a quantity not to exceed a 92-day supply.
3. Prenatal Vitamins minimum quantity is 90 and maximum quantity is 102.

Requests for overrides should go to the MHP Clinical Call Center.

Quantity Limits:

All Quantity Limits are identified in the Preferred Drug List. The Preferred Drug List can be found at http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

Refills:

- All refills must be dispensed in accordance with State and Federal requirements.
- Refill prescriptions must be dispensed pursuant to the orders of the physician, but not more than one year from the date of the original prescription.
- Refills must not exceed 5 refills (plus one original).
- For DEA code = "3", "4", "5": allow up to 5 refills (plus one original) or 6 months, whichever comes first.
- For DEA code = "2" no refills are allowed; a new prescription is required for each fill.

Early Refill Overrides (NCPDP Reject Code 79):
Claims will reject for refill requests for in which more than 25% of the previous days' supply still remains. Pharmacies may request an override for claims that reject for early refill. To request an override, pharmacies must contact the Pharmacy Call Center at (800) 918-7545:

Pharmacy Representatives should be prepared to provide the appropriate submission clarification code (reason) for the early refill request. See below:

Submission Clarification Code / Description	
00/ not specified	**Not acceptable for early refill override**
01/ no override	**Not acceptable for early refill override**
02/ other override	**Not acceptable for early refill override**
03/ vacation supply	Acceptable; use for vacations and LTC leave of absence
04/ lost prescription	Acceptable
05/ therapy	Acceptable; use when prescriber changes dose
06/ starter dose	**Not acceptable for early refill override**
07/ medically necessary	**Not acceptable for early refill override**

Provider Dispensing/Compounding Fees

- The dispensing fee for in-state pharmacies is $4.75. For maintenance drugs, one dispensing fee per 30 days is permitted. However, if there are extenuating circumstances in an individual case which, in the judgment of the prescribing physician, dictate a shorter prescribing period, the supply may be for less than 30 days, in which case a dispensing fee would be paid for each fill as prescribed.

- The dispensing fee for out-of-state pharmacies is $3.65.

- An additional compounding fee is paid in addition to the dispensing fee for compound drug claims. (See page 12.)

- Exceptions:
  - There is a limited dispensing fee for LTC claims; i.e. one per every 25 days per patient per covered drug (per GPI).
  - No dispensing fee for glucometers.

Recipient Payment Information

Vermont programs have no deductibles and no benefit maximums.

When traditional Medicaid coverage is primary, copayments are:

- $1 if allowed amount is equal to or less than $29.99.
- $2 if allowed amount is greater than or equal to $30.00 but less than or equal to $49.99.
- $3 if allowed amount is equal to or greater than $50.00.

Exceptions (no copayments apply):

- Patient is 20 years old or younger (based on Eligibility File)
- Drug is a family planning drug
- Patient is pregnant or in the 60-day post-pregnancy period (requires a prior authorization obtained by calling MedMetrics Clinical Call Center at 800-918-7549)
- Claim is licensed nursing home (LTC) claim (**requires PATIENT LOCATION = "03" on the claim to indicate licensed nursing home LTC)**
- Medical supplies

When Healthy Vermonter coverage applies, the beneficiary pays the full allowed amount.

Full-benefit dual eligible beneficiaries (those who have both Medicaid and a Medicare Part D Plan) are responsible for copayments up to $6.00 charged by the Part D Plan for 2009. For those beneficiaries who are enrolled in a VPharm (Part D wrap) program, Part D plan deductibles and coinsurance should be billed to VPharm. For further clarification on how VPharm plans interact with Medicare Part D, see:

http://ovha.vermont.gov/for-providers/ovha-plan-coverage

Coordination of Benefits

The following provides information on submitting COB claims.

Claim segment and field requirements are detailed in the Consolidated Payer Specification Sheet.

Required information on a secondary claim may include:

- Submitted Patient Pay
- Other Coverage Code
- Other Payer Amount
- Other Payer Date
- Other Payer ID Qualifier
- Other Payer ID

The state-assigned Other Payer IDs can be found on the Active Payer and PDP Sponsor Lists found at

http://ovha.vermont.gov/for-providers/Active%20Carrier%20Codes%201%2007.pdf. These lists are:

- insurance carriers / sponsors for COB claims filed under PCN VTM
- Medicare Part D Plan Sponsors for COB claims filed under PCN VTD

Providers may submit up to three segments of information when there are multiple other payers.

***Required fields*:**

Submitted Patient Pay (NCPDP Field # 433-DX): Required on all secondary claims. The submitted Patient Pay field details the amount of the copay required by the member's primary payer.

Other Payer Coverage Code (NCPDP Field #308-C8): Required on all secondary claims. The Other Payer Coverage Code indicates the type of coverage the other insurer is providing for the claim. (See chart below for possible scenarios and circumstances.)

OCCURRENCE	CORRECT OTHER COVERAGE CODE TO USE	(OVHA – VTM) Processing Policy Vermont Coverage Secondary to Alternate Insurance	(OVHAD – VTD) Processing Policy Vermont Coverage Secondary to Medicare Part B and Part D
The primary insurance plan pays a portion of the claim.	2 = Other coverage exists, payment collected from primary insurance.	Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount. Claim will process based on Medicaid allowed amount. Leaving this field blank is not permitted as it will result in the State paying the entire claim in full. These claims will be subject to recoupment.	Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount – claim will pay based on member cost share from PDP. Limitations: 1) OCC2 does not apply to full-benefit duals except in the event that the PDP makes a payment for a CMS Part D excluded drug (e.g. benzodiazepine). 2) Payment limited to $6.00 for VPharm 100% LIS members. Leaving this field blank is not permitted as it will result in the State paying the entire claim in full. These claims will be subject to recoupment.
The primary insurance rejects the claim.	3 = Other coverage exists, claim rejected by primary insurance.	**Only to be used for over-the-counter drugs.** Claims submitted with an OCC = 3 will be subject to an edit to determine if drug is OTC; if so, the state will pay claim if all other state criteria is met. State would prefer Other Payer Reject Code, but field is not currently required. **For non-OTC drugs:** If the primary payer denies a claim because the drug requires a prior authorization or it is a non-formulary drug, then the primary carrier's prior authorization procedures must be followed.	Claims submitted with an OCC = 3 will be subject to an edit to determine if drug class is Excluded from Part D coverage by CMS; if so, state will pay claim if all other state criteria is met. If product is not an Excluded Drug from CMS for Part D coverage, state will reject claim. State would prefer Other Payer Reject Code, but field is not currently required. OCC=3 does not apply to Medicare Part B.

OCCURRENCE	CORRECT OTHER COVERAGE CODE TO USE	(OVHA – VTM) Processing Policy Vermont Coverage Secondary to Alternate Insurance	(OVHAD – VTD) Processing Policy Vermont Coverage Secondary to Medicare Part B and Part D
The primary insurance carrier processes the claim but does not make a payment because: **a) The member is in a deductible period,** **b) The member is in the Part D donut hole, or** **c) The payment is less than the patient's copayment.**	4 = Other coverage exists, payment not collected from primary	Requires Submitted Patient Pay field and complete COB segment. Claim will pay based on Medicaid allowed amount. OCC = 4 is not to be used when the primary claim has been denied by the primary insurance plan because the drug requires a prior authorization or it is a non-formulary drug. If found during a State audit, these claims will be subject to recoupment.	To be used when member has deductible or "donut hole" and primary payer is not making payment on claim; requires Submitted Patient Pay field and complete COB segment. Claim will pay based on member cost share from PDP. Also used for Part B deductible. Limitations for OCC4: 1) Does not apply to Part D claims for full-benefit duals, and 2) Payment limited to $6.00 for VPharm 100% LIS members. OCC = 4 is not to be used when the primary claim has been denied by the Part D Plan because the drug requires a prior authorization or it is a non-formulary drug. If found during a State audit, these claims will be subject to recoupment.
The primary insurance plan rejects the claim because coverage no longer exists.	7 = Other coverage exists, not in effect on Date of Service (DOS)	To be used if member's other coverage no longer exists; state will process claim.	Claim will reject.
The Part D Plan processes the claim with a negative amount for payment.	8 = Billing for Copay	Not applicable	(*Only used when Other Payer Paid Amount is $<0*) Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and *negative* Other Payer Paid Amount. Claim will pay based on member cost sharing.

Other Payer ID Qualifier (NCPDP Field #339-6C): Required on claims where the Other Coverage Code (OCC) = "2" or "8". The Other Payer ID Qualifier will always be "99 – Other", since the list is a state-issued list of payers.

Other Payer ID (NCPDP Field #339-7C: Required on claims where the Other Coverage Code (OCC) = "2" or "8". The Other Payer ID is a unique three-digit carrier code that identifies the other insurer; the state issues and maintains that list of codes. For Medicare Part D secondary claims, the state maintains a list of the Part D plan sponsors. For other Medicaid secondary claims, the state maintains a complete list of potential insurers.

Other Payer Amount Paid (NCPDP Field #431-DV): Required on claims where the Other Coverage Code (OCC) = "2" or "8". The Other Payer Amount Paid is the dollar amount of the payment received from the primary payer(s).

Other Payer Date (NCPDP Field #443-E8): Required on all secondary claims. The Other Payer Date is the payment or denial date of the claim submitted to the other payer.

Other Payer Reject Code (NCPDP Field #472-6E): The Other Payer Reject Code is not currently required, but is supported by the state when the Other Coverage Code (OCC) = 3.

Medicare

Part B:

Vermont program coverage is always secondary to Medicare Part B Coverage. As of July 1, 2006, Medicare Part B prescription drug claims with NDCs are processed by MedMetrics Health Partners. EDS is no longer processing Medicare Part B crossover and paper claims.

Medicare Part B Covered Drugs:

- Oral Cancer Drugs
- Immunosuppressants
- Nebulizer Solutions
- Diabetic Supplies

To override the "Medicare as primary" requirement, pharmacies must first bill Medicare B, receive a denial, and then contact the MedMetrics Clinical Call Center at 1-800-918-7549. Pharmacies are no longer able to override at point of sale by entering 88888 in the other payer ID field.

Part D:

Effective January 1, 2006, Vermont beneficiaries who are Medicare eligibles will be enrolled in a Part D plan for primary coverage, with only a secondary benefit provided by Vermont programs.

Use an E1 request to determine if the member is enrolled in a Part D plan. If the member is enrolled in a Part D Plan, the E1 response will identify where to send the primary payment request as well as the processing information to submit to Medicaid for any secondary claim.

Vermont Medicaid members who have Part D coverage are eligible for a "wrap" benefit by the state. Depending on a member's eligibility and the product that you are dispensing, this benefit may be a financial or a formulary wrap to the Part D vendor's (PDP's) benefit. Generally, coverage parallels coverage in Vermont programs (Medicaid, VHAP, VHAP Pharmacy, VScript, and VScript Expanded). See the Vermont Pharmacy Programs Coverage Chart for the most current information:

http://ovha.vermont.gov/for-providers/ovha-plan-coverage

See the MedMetrics Health Partner Consolidated Payer Sheet for claims submittal information.

Part C:

As of January 1, 2007, Medicare members in Vermont will have the option of joining a Medicare Part C plan. Medicare Part C consists of several Medicare Advantage Plan choices that are Medicare-approved and administered by private insurance companies.

- The Medicare Advantage Plans will replace Part A and Part B for members who choose to join. Some Medicare Advantage Plans also include drug coverage (Part D).

- For those plans that do not include Part D drug coverage, the member will need to have a separate Part D Plan in order to receive a pharmacy benefit.

When a beneficiary is covered by both Medicare B and D, drug claims must be processed by the appropriate insurer prior to submitting any balances to MedMetrics. OVHA will closely monitor this process.

Payer Specifications

Current specifications can be found on the website for the Office of Vermont Health Access on the Provider Services and Claims Processing Page at:

http://ovha.vermont.gov/for-providers/medmetrics-health-partners-mhp-billing-information

The Payer Specifications include details on claims submissions, host information, claims processing messages, submission clarifications, DUR information, DUR service codes, and COB messages.

BIN/PCN Numbers

Claims for Vermont Members	
ANSI BIN #	**610593**
Processor Control #	**VTM**
Group #	VTMEDICAID
Carrier	MPSOVHA
Provider ID #	NCPDP Number
Cardholder ID #	Vermont Medicaid ID Number
Prescriber ID #	Prescriber NPI Number
Product Code	National Drug Code (NDC)

Claims for Vermont Medicaid Members w/Part D Coverage	
ANSI BIN #	**610593**
Processor Control #	**VTD**
Group #	VTMEDICAID
Carrier	MPSOVHAD
Provider ID #	NCPDP Number
Cardholder ID #	Vermont Medicaid ID Number
Prescriber ID #	Prescriber NPI Number
Product Code	National Drug Code (NDC)

Provider Reimbursement

Provider Payment Algorithm

- Vermont Medicaid is the payer of last resort after other insurers.

- Vermont Medicaid programs pay the lesser of:

    1. AWP – 11.9% + dispensing fee
    2. HCFA FUL + dispensing fee
    3. MAC + dispensing fee
    4. U/C (includes dispensing fee)

*Secondary Claims (claims when other insurance is primary)**

1. Part D: For secondary claims when the Part D plan is the primary payer, Vermont Medicaid pays the amount designated in the claims "Patient Pay" field.

2. Non-Part D: When other insurance is the primary payer, Vermont Medicaid pays the allowed amount as determined in the above payment algorithm reduced by the primary insurance payment.

* See Coordination of Benefits, pages 22 to 25.

Provider Reimbursement Schedule

The payment and Remittance Advice schedule is weekly.

Appendix A

VScript Covered Maintenance Drug Categories

- ADD/ADHD Treatments
- Adrenergic Agents
- Alzheimer's Disease Medications
- Angina(Chest Pain) Treatments
- Anticoagulants/Blood Thinners
- Anticonvulsants/Epilepsy Treatments
- Antidepressants
- Anti-Inflammatory Agents
- Antimalarials
- Antipsychotics/Schizophrenia Treatments
- Antiretrovirals
- Anti-ulcer/Reflux Treatments
- Anxiety Treatments
- Arthritis Treatments
- Asthma/COPD Treatments
- Bipolar Treatments
- Blood Cell Stimulators
- Cancer meds
- Cholesterol-Lowering Agents
- Contraceptives (oral/systemic)
- Diabetic Therapy
- Digestive Enzymes
- Diuretics
- Electrolytes & Miscellaneous Nutrients
- Estrogens
- Folic Acid Preparations
- Gall Stone/Kidney Stone Treatments
- Heart Arrhythmia Treatments
- Heart Failure Treatments
- Hypertension Treatments
- Irritable Bowel Treatments
- Local (topical) Anesthetics
- Non-Narcotic analgesics
- Ophthalmic preparations
- Other Cardiovascular Treatments
- Other CNS Treatments
- Overactive Bladder Treatments
- Parkinson's Disease Medications
- Progesterone
- Systemic Steroids (Glucocorticoids/Mineralocorticoids)
- Testosterone Replacement Therapy
- Thyroid Preparations
- Tuberculosis (TB) Treatments
- Urinary Antibacterials

Appendix B

VScript Non-Covered Drug Categories

Non-Coverage Based Upon General Use for the Treatment of Acute Conditions

- Antibiotics (most classes)
- Antidotes **(agents used to treat accidental poisoning or overdose)**
- Antihistamines
- Antiseptics
- Antithyroid preparations
- Antivirals
- Biologicals
- Coal tar **(tar-based skin treatments for conditions like psoriasis or flakey skin)**
- Cough & cold preparations
- Dermatologic treatments
- Diagnostic meds
- Diarrhea Medications
- Digestants
- Emollients protectives **(topical treatments for dry skin)**
- Fertility treatments
- Fungal treatments
- Hemorrhoidal preparations
- Iodine therapy **(iodine-based expectorants used to decrease mucus in various respiratory conditions)**
- Laxatives
- Medical supplies
- Multivitamins
- Muscle relaxants
- Narcotic analgesics
- Nasal preparations
- Nausea treatments
- Obesity preparations
- Otic (ear) preparations
- Parasite treatments
- Sedative/hypnotics
- Vaginal products
- Vitamins (fat-soluble)
- Vitamins (water-soluble)